Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: PEDRO NOSNIK, MD 4100 W 15TH STREET, STE 206 PLANO, TX 75093	MFDR Tracking #: M4-10-2711-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: NETHERLANDS INSURANCE CO Box #: 19	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the table of disputed services: "pre authorization #925995 & this was approved by the adjuster"

Amount in Dispute: $827.50

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical dispute concerns reimbursement for medical treatment the requestor provided to the claimant on June 8, 2009. The requestor has indicated that preauthorization was given for the services underlying the disputed charges. However, the requestor has only provided an alleged preauthorization number, and has not actually produced any documentation reflecting the carrier's preauthorization of the services underlying the disputed charges. Nevertheless, the carrier will be re-reviewing the disputed medical bill, and if it determines that any additional reimbursement is due, the carrier will tender payment to the requestor".

Response Submitted by: American First c/o Flahive, Ogden & Latson, 504 Lavaca Suite 100, Austin, Tx 78701

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
6/8/09	95920-26-59	53.68 ÷ 36.0666 x $104.76 = $155.92 x 3 = $467.76	$468.27	$467.76
6/8/09	95955-26	53.68 ÷ 36.0666 x $48.18 = $71.71	$71.79	$71.71
6/8/09	95861-26	53.68 ÷ 36.0666 x $75.98 = $113.09	$113.21	$113.09
6/8/09	95925-26	53.68 ÷ 36.0666 x $26.72 = $39.77	$39.81	$39.77
6/8/09	95926-26	53.68 ÷ 36.0666 x $26.33 = $39.19	$39.23	$39.19
6/8/09	95900-26	53.68 ÷ 36.0666 x $20.67 = $30.76	$30.08	$30.08
6/8/09	95934-26	53.68 ÷ 36.0666 x $24.87 = $37.02	$24.87	$24.87
6/8/09	95936-26	53.68 ÷ 36.0666 x $27.01 = $40.20	$40.24	$40.20
			Total Due:	$826.67

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.

3. 28 Tex. Admin. Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of health care.
4. 28 Tex. Admin. Code §137.100 sets out the treatment guidelines for disability management.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 7/14/2009

   - 197 – Authorization. Treatment rendered is in excess of the state specified treatment guidelines (ODG).

Issues

1. Did the requestor follow the treatment guidelines for the services in dispute and were the disputed services preauthorized by the insurance carrier?
2. Is the requestor entitled to reimbursement?

Findings

1. The provider billed the above listed disputed services for intraoperative monitoring and appended modifier 26 (professional component) to all the disputed codes and appended modifier 59 (distinct procedural service) to CPT code 95920 for inpatient services according to the submitted bill. The insurance carrier denied all of the disputed services with above reason code "197". Pursuant to rule §134.600(p) Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions… and (12) treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier. Pursuant to rule §137.100(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp,* excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care. The provider billed CPT code 95920-26-59 with primary diagnosis code 722.10 (lumbar intervertebral disc without myelopathy) and billed the rest of the disputed CPT codes with primary diagnosis code 724.4 (thoracic or lumbosacral neuritis or radiculitis, unspecified). According to the Official Disability Guidelines (ODG) for June/2009 under diagnosis codes 722.10 and 724.4, not all of the disputed services are listed for approval. Therefore, pre-authorization is required for the services not approved. The requestor did not include a copy of the preauthorization from the inusurance carrier in the dispute. The Division contacted the requestor on September 14, 2010 by email and requested a copy of the preauthorization request and a copy of the preauthorization approval. The Division received 3 pages of a UniMed Direct approval which does not include the first page(s). No preauthorization request was received from the requestor. Although the preauthorization number the requestor listed on the bill is not supported by the partially submitted UniMed Direct approval, it does support approval for surgery with start date 5/6/2010 and end date 7/8/2010 and includes: "Intra-operative monitoring to be done by Dr. Pedro Nosnik, MD (approved by carrier) (95920, 95925, 95926, 95928, 95929, 95934, 95936, 95900, 95955, 95861, A4556 & A4558)". Therefore, reimbursement to the requestor for the above disputed codes is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $826.67.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $826.67 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

		6/2/2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.